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| --- | --- |
| **NAME:** ----------------------------------------------------------------------الاسم:**MR #:** ----------------------------------------------------------رقم الملف الطبي:.**National ID#:** -------------------------------------------رقم الهوية/ الإقامة:.**SEX:** ---------------**/** الجنس:. **D.O.B:** ---------------------------تاريخ الميلاد:**NATIONALITY:** ------------------------------------------------------الجنسية:. **Clinic:** -----------------**/** العيادة:. **Doctor:** --------------------------الطبيب:.  | A picture containing text  Description automatically generatedA picture containing text  Description automatically generated المركز الطبي الجامعي |
| **OCCURRENCE / VARIANCE REPORT** **(لا يستخدم هذا النموذج للأغراض الجزائية)** **(Not for Retributive Purposes)** |
| **Date of Incident:** ---------------------------------- **Time of Incident:** ---------------------- **Incident Location:** -------------------------------------------**Date of Report:** ------------------------------------ **Time of Report:** ----------------------- **Reporting Area:** ---------------------------------------------- |
| **SENTINEL EVENT: □ YES □ NO** **If yes please specify:** ------------------------------------------------------------- | **Involved Person: □ Patient □ Staff** **□ Other:** ---------------------------------------------------------------------------- |
| **Clinical Practice / Procedure** | **Medication** | **Communication / Documentation** | **Degree OF HARM** |
| **□ Consent****□ Patient Privacy****□ Reporting of test result****□ Medical notes unavailable****□ Policy not available****□ Refused of cannulation****□ I.V. not given****□ I.V. infiltration****□ Wrong solution type****□ Procedure/s not followed****□ Others** --------------------------- | ---------------------------------------**□ Medication prescribing error****□ Medication dispensing error****□ Medication administration error****□ Medication Storage error****□ Adverse drug reaction****□ Others**--------------------------------------- | **□ Patient Identification****□ Missing files****□ Order error****□ Documentation****□ Medical records unavailable****□ Policy not available****□ Confidentiality****□ Delay in responding****□ Others**--------------------------------------- | **□ No Harm****□ Minor Injury****□ Severe Injury****□ Permanent loss of function or disability** **□ Death** |
| **Infection Control** | **Patient Fall** | **Laboratory Specimen** |
| **□ Needle stick** **□ Sharps injury****□ Isolation precaution compliance****□ Used instrument storage/collection****□ Others** -------------------------- | **□ Out of bed □ Off chair****□ Off scale or equipment****□ Found on the floor****□ Unknown □ Others** | **□ Technical error****□ Transcription error****□ Phlebotomy complications****□ Time delay in processing****□ Result reporting problem****□ Infection****□ Others**--------------------------------------- | **□ Improper labeling****□ Unlabeled specimen container****□ Improper specimen****□ No requisition****□ Incomplete orders****□ Missed specimen****□ Sample mix-up****□ Patient injured (hematoma, etc.)** |
| **Environmental Safety** |
| **□ Hazardous material****□ Security □ Safety □ Fire** **□ Medical equipment****□ utility □ others** ------------ |
| **Other Types of Event:** |
| ---------------------------------------------------------------------------------------------------------------------------------------------------------------------- |
| **Brief description of the incident:** |
| --------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------**Person's current condition:** ------------------------------------------------------------------------------------------------------------------------------------ |
| **Supervisor Informed?**  **(not required unless immediate action is required) □ Yes □ No Physician informed? □ Yes □ No**  |
| **Immediate Corrective Action:** ----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------- |
| **Reported by: Name:** -------------------------------------------------------------------- **Clinic/Place:** -------------------------------------------------------**Mobile/Ext. no.:** ------------------------------------------------------------------------ |